



**THE COMMONWEALTH OF MASSACHUSETTS
 EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
 DEPARTMENT OF PUBLIC HEALTH
 DIVISION OF HEALTH PROFESSIONS LICENSURE
 239 CAUSEWAY STREET, SUITE 500
 BOSTON, MA 02114
 617-973-0806
www.mass.gov/dph/boards**

BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

NCCPA RELEASE FORM

Complete this form and mail to:

NCCPA
 12000 Findley Road
 Suite 200
 Duluth, GA 30097

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc. [NCCPA] to release to the:

MA Board of Registration of Physician Assistants
 239 Causeway Street, Suite 500
 Boston, MA 02114

Any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the MA Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the NCCPA and its agents and employees from any liability arising out of its compliance with such a request for information.

Signature of Applicant	Date	
Applicant Name : _____		
Last	First	Middle
Previous Name : _____		
Last	First	Middle
Address : _____		
Number	Street	Apt. #
City/Town		State
		Zip

Telephone [day] : _____

Date of Birth : ____/____/_____
 Dd/mm/yyyy

Social Security Number : _____

NCCPA Certificate Number : _____

Date of Exam : ____/____/_____
 Dd/mm/yyyy